PRINTED: 12/07/2007
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G159	A. BUILDING _____ B. WING _____	C 11/29/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARECO 02	6613 6TH STREET, NW WASHINGTON, DC 20012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS A follow-up to the initial survey which was completed on 4/13/2007 was conducted on 11/28/2007 after the facility submitted a Plan of Correction which alleged compliance on 5/10/2007. Observation, staff and interview and a review of the facility ' s presented plans of correction revealed the provider failed to enact and enforce the necessary measures required to abate the deficiencies cited below.	W 000		
W 124	483.420(a)(2) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore the facility must inform each client, parent (if the client is a minor), or legal guardian, of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and of the right to refuse treatment. This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility continues to be without the services of a legal guardian to insure the proper and necessary communication as required by this section. (Client #3) The finding includes: On 4/13/2007 the state agency conducted this facility ' s annual recertification and cited that " no system had been established to provide guardianship for consent or legally sanctioned advocacy " for Client #3. The provider submitted their plan of correction and indicated that this deficiency would be resolved by 5/31/2007. The state agency conducted a monitoring visit on 11/28/2007 and found that Client #3 was still without the services of any legally sanctioned	W 124	W124 The QMRP has submitted a request for guardianship to the Dept of Disability Services per agency and DDS policy. To date a hearing date has not been assigned. The QMRP will make monthly follow up calls to determine status and document in the monthly reviews. 12/31/07	

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ADMINISTRATION
2007 DEC 19 P 2:41

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Dana L. Tolly | 12/17/07

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 124	Continued From page 1 advocate. The facility ' s Qualified Mental Retardation Professional (QMRP) was interviewed on 11/28/2007 at 3:17pm and she indicated that a request for guardianship had been submitted to the courts on behalf of this client, but as of the date of the monitoring, no guardian had been assigned.	W 124		
W 189	483.430(e)(1) STAFF TRAINING PROGRAM The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. This STANDARD is not met as evidenced by: Based on staff interview and record review the facility failed to ensure staff received the proper and necessary training to ensure client privacy; The findings include: 1. On 4/13/2007 the state agency conducted this facility ' s annual recertification and found the facility ' s practices to be deficient in the area of client privacy (W130). The provider submitted their plan of correction and indicated that the QMRP would ensure the facility ' s staff received further in-service training on the rights-of-residents and on how to assist them in observing privacy by 5/31/2007. This proactive measure was to be employed as a means of ensuring that the clients as well as the facility ' s staff would better understand how to ensure and manage a client ' s privacy. At 3:23pm during the state agency ' s monitoring visit on 11/28/2007, the QMRP presented a sign-in sheet that was dated 5/21/2007 for staff training on " appropriate clothing (for modesty), bathing, dressing, and grooming " . Of the twelve staff presently on the current work schedule, only two was in	W 189		

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W 189	Continued From page 2 attendance and signed for the 5/21 training. There was no evidence on file at the time of survey to substantiate that the facility ensured that its staff received the proper and necessary training to maintain and manage client privacy. 2. On 4/13/2007 the state agency conducted this facility ' s annual recertification and found the facility ' s practices to be deficient in the area of reporting injuries of unknown origin (W153). The provider submitted their plan of correction and indicated that " all staff have been retrained in implementing incident management procedures " on 5/10/2007. In addition, the facility further denoted that " the agency will strictly enforce its policy on holding individuals accountable, which may include termination for failure to report such occurrences. " At 3:37pm during the state agency ' s monitoring visit on 11/28/2007, the QMRP presented a sign-in sheet that was dated 9/11/2007 for staff training on " Incident Reporting " . Of the twelve staff presently on the current work schedule, only two was in attendance and signed for the 9/11 training. There was no evidence on file at the time of survey to substantiate that the facility ensured that its staff received the proper and necessary training to maintain and manage the reporting of injuries of unknown origin. 3. On 4/13/2007 the state agency conducted this facility ' s annual recertification and found the facility ' s practices to be deficient in the area of implementing a client ' s behavior support plan (BSP) (W193 & W249). The provider submitted their plan of correction and indicated the following: a. For Citation #1 to address the behavioral supports for Client #2, the facility ' s response indicated that " Staff [was] trained on implementation of the BSP's for all residents on	W 189	W189 1. Training on privacy is addressed in the agency's training on Resident's Rights. This occurs at New Hire Orientation, upon deployment to a facility and annually thereafter. Copies of documentation will be filed at the facility and at the agency's main office. 2. All available training records will be filed in the facility and available for review within 3 days of the actual training. 3. a. Training on BSP's occurred on 3/9/07 and 3/21/07. new employees received individual training upon deployment. Such trainings will be documented on the New Employee Checklist and filed at the facility within 3 days of the actual training.	

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W 189	Continued From page 3 March 9 2007. A second session was scheduled for those who missed the first offering. In addition, all staff [is] trained on behavior management prior to or upon deployment into the home ... All staff [has] been retrained on implementation of all BSP's including the one developed for Client #2. Staff will not be assigned to support clients until they have a fundamental understanding of the BSP. This acknowledgement will be documented. " At 3:40pm during the state agency ' s monitoring visit on 11/28/2007, the QMRP presented a sign-in sheet that was dated 5/22/2007 for staff training on " Behavior Support Plans " . Of the twelve staff presently on the current work schedule, only one was in attendance and signed for the 9/11 training. There was no evidence on file at the time of survey to substantiate that the facility ensured that its staff received the proper and necessary training to maintain and manage the implementation of a client ' s behavior management plan. b. For Citation #2 to address the behavioral supports for Client #3, the facility ' s response indicated that " Staff will receive additional training on implementing the active treatment routine for client #3 to properly support her in managing behavior. " In addition, the facility further alleges that " the staffing patterns will be reviewed with the governing body to determine how best to support Client #3 ' s [behavioral needs]. " At 3:40pm during the state agency ' s monitoring visit on 11/28/2007, the QMRP presented a sign-in sheet that was dated 5/22/2007 for staff training on " Behavior Support Plans " . Of the twelve staff presently on the current work schedule, only one was in attendance and signed for the 9/11 training. In addition, the QMRP was interviewed on	W 189	b. In addition to training on BSP's, staff received additional training on Active Treatment, which is a proactive measure of Client #3's behavior management. Documentation of these trainings will be maintained at the facility within 3 days of the actual training. 12/31/07	

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W 189	Continued From page 4 11/28/2007 at 3:45pm and she indicated " that the staffing pattern(s) were not changed to address this issue, but the team decided that more training was to be the best means of addressing thie client ' s needs. " There was no evidence on file at the time of survey to substantiate that the facility conducted the meeting with the governing body or ensured that its staff received the proper and necessary training to maintain and manage the implementation of a client ' s behavior management plan.	W 189		
W 263	483.440(f)(3)(ii) PROGRAM MONITORING & CHANGE The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian. This STANDARD is not met as evidenced by: Based on staff interview and record review the facility failed to ensure the provisions of a written informed consent prior to the use of psychotropic medications and sedation on a client. [Client #3] The finding includes: On 4/13/2007 the state agency conducted this facility ' s annual recertification and found the facility ' s practices to be deficient in the area of garnering parental or legally sanctioned consent prior to implementing the use of psychotropic medications (W263). The provider submitted their plan of correction and indicated that this deficiency would be resolved by 5/31/2007. The state agency conducted a monitoring visit on 11/28/2007 and found that Client #3 was still without the services of a legally sanctioned advocate. The facility ' s Qualified Mental	W 263	W263 Cross reference response for W124	

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W 263	Continued From page 5 Retardation Professional (QMRP) was interviewed on 11/28/2007 at 3:17pm and she indicated that a request for guardianship had been submitted to the courts on behalf of this client, but as of the date of the monitoring, no guardian had been assigned. [Reference Citation W124]	W 263		
W 418	483.470(b)(4)(ii) CLIENT BEDROOMS The facility must provide each client with a clean, comfortable mattress. This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure the integrity of a client ' s mattress for one of the five clients residing in the facility. [Client #1] The finding includes; During the environmental inspection on the 11/28/2007 monitoring visit, Client #1 ' s mattress was found to be uneven and lumpy to the touch. The bed springs could be felt through the bedspread and the edge of the mattress sloped excessively on the side away facing the middle of the room. The facility ' s QMRP was interviewed on 11/28/2007 at 4:48pm and she indicated she was not aware Client #1 ' s mattress was bad and took note of the deficiency. There was no evidence presented or on file at the time of survey to substantiate that the facility employed the necessary measures to prevent the recurrence of this deficient practice.	W 418	W418 The mattress will be replaced. In the future, mattress inspections will occur, minimally, during quarterly Internal Environment of Care Surveys. Mattresses of unacceptable condition will be replaced. 12/31/07	
W 440	483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills at least quarterly for each shift of personnel.	W 440		

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W 440	Continued From page 6 This STANDARD is not met as evidenced by: Based on staff interview and record review, t the facility failed to ensure that evacuation drills occurred quarterly for all shifts. The finding includes: On 4/13/2007 the state agency conducted this facility ' s annual recertification and found the facility ' s practices to be deficient in the area of conducting fire drills (W440). The provider submitted their plan of correction and indicated that " the Residential Director will review the evacuation drills minimally every quarter to ensure that each shift has the minimum amount of practice drills. Reviews will be documented and any problems noted in the drills will be immediately reported to the QMRP. " This action was to be effective and resolved by 5/31/2007. The facility ' s QMRP was interviewed on 11/28/2007 at 3:55pm and she confirmed that the facility ' s work shifts are as presented below: 1. Weekday shifts: 7-3pm, 3-11pm, and 11-7am. 2. Weekend shifts: Same general shifts as above, but includes an overlapping 11-9am shift. The state agency conducted a monitoring visit on 11/28/2007 and found the following fire drills on record: 1. 04/06/07 7:00am 2Minuets 5Sec 2. 06/18/07 6:45pm 3Minutes 10Sec 3. 07/02/07 7:40am 5Minutes 4. 07/15/07 9:45? 5Minutes 5. 7/29/07 2:00am 3min 6. 8/7/07 8:00am 3min	W 440	W440 The Residential Director will be retrained on the protocol for ensuring that fire drills are completed and reviewed per agency policy. Additionally, fire drills will be inspected during Internal Environment of Care Surveys. 12/31/07	

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W 440	Continued From page 7 7. 8/17/07 8:00pm 5min 8. Fire Drill filed but it does not have date, hour completed or total evacuation minutes.* 9. 10/17/07 8:30pm 4min 10. 10/31/07 5:00pm 2min *Document indicates the fire drill was conducted by Staff " A.G. " As documented, only one fire drill was held in the months of March and June of 2007; No fire drills were conducted on May or September of this year; Two shifts recorded having drills in August and October of 2007; and there was no evidence that the Residential Director had reviewed or ensured that " each shift had the minimum amount of practice drills " as stipulated in the Plan of Correction There was no evidence on file or presented at the time of survey to substantiate that the facility ensured the proper and necessary management of fire drills as required by this section.	W 440		
W 455	483.470(l)(1) INFECTION CONTROL There must be an active program for the prevention, control, and investigation of infection and communicable diseases. This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure that staff received the proper and necessary training to manage infection controls in a closed environment. The findings include: On 4/13/2007 the state agency conducted this facility ' s annual recertification and found the	W 455		

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W 455	Continued From page 8 facility ' s practices to be deficient in the area of implementing infection control procedures to prevent the spread of communicable diseases. The provider submitted their plan of correction and indicated that " staff will receive additional training on infectious controls by the Director of Nursing " . This action was to be effective and resolved by 5/31/2007. The facility ' s QMRP was interviewed on 11/29/2007 at 4:26pm and she stated that there have been several changes in the organizational structure of the agency and that she was not aware of who currently held the title and position of Director of Nursing. In addition, she pointed out that the training had not been completed There was no evidence presented or on file at the time of survey to substantiate that the Director of Nursing has conducted this training as stipulated on the Plan of Correction.	W 455	W455 During the monitoring survey, the QMRP noted that she did not believe the agency employed a "Director of Nursing". Rather the agency employed an "RN Supervisor". A training was conducted by the previous RN Supervisor who retained the documentation. Such evidence will be obtained and maintained at the facility. 12/31/07	

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I 000	INITIAL COMMENTS A monitoring visit to the 4/13/2007 re-certification survey was conducted on 11/29/2007 to verify the facility's compliance and implementation of their Plan of Correction. Observation, staff interview and a review of the facility ' s presented plans of correction revealed the provider failed to enact and enforce the necessary measures required to abate the deficiencies cited below.	I 000		
I 127	3505.4(a)(5) FIRE SAFETY Each GHMRP shall have on the premises the following items: (a) Written policies and procedures that are approved by the Fire Chief, which shall be kept readily accessible to staff and residents and shall include the following: (5) The evacuation routes; This Statute is not met as evidenced by: The facility failed to ensure the provisions of this section as identified below: During the monitoring visited on 11/28/2007, the facility failed to ensure that the " evacuation route(s) " was posted in the basement living area. Note: The basement houses a recreational space, a secondary bathroom, laundry facilities, and both a food and chemical storage area. There is also two separate means of egress in the basement, one in the laundry area and another in the open living space.	I 127	I 127 The evacuation route has been posted. 12/31/07.	
I 180	3508.1 ADMINISTRATIVE SUPPORT Each GHMRP shall provide adequate	I 180		

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I 180	Continued From page 1 administrative support to efficiently meet the needs of the residents as required by their Habilitation plans. This Statute is not met as evidenced by: The facility failed to ensure the provisions of this section as identified below: Staff interview and record review on 11/28/2007 revealed the facility failed to ensure that staff received the proper support to ensure resident ' s privacy and implementation of their Behavior Management Plan (BMP). [Reference Licensure Citation 3510.3]	I 180	I 180 Cross-reference response for W189 on federal report.	
I 187	3508.5(d) ADMINISTRATIVE SUPPORT Each GHMRP shall have an organization chart that shows the following: (d) The lines of authority. This Statute is not met as evidenced by: The facility failed to ensure the provisions of this section as identified below: The facility ' s QMRP was interviewed on 11/29/2007 at 4:26pm and she stated that there have been several changes in the organizational structure of the agency and that she is not aware of who currently holds the title and position of Director of Nursing. In addition, she pointed out that the current organizational chart that was posted in the home was not current and does not show who currently holds the title and position of Director of Nursing. That survey team verified that the current organizational chart was dated 08/2007. There was no evidence presented or on file at the time of survey to substantiate that the Director of Nursing has conducted this	I 187	I 187 The most recent organization chart has been reviewed and filed in the facility. 12/19/07	

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I 187	Continued From page 2 training as stipulated on the Plan of Correction.	I 187		
I 222	3510.3 STAFF TRAINING There shall be continuous, ongoing in-service training programs scheduled for all personnel. This Statute is not met as evidenced by: The facility failed to ensure the provisions of this section as identified below: 1. On 4/13/2007 the state agency conducted this facility ' s annual recertification and found the facility ' s practices to be deficient in the area of resident privacy (W130). The provider submitted their plan of correction and indicated that the QMRP would ensure the facility ' s staff received further in-service training on the rights-of-residents and on how to assist them in observing privacy by 6/31/2007. This proactive measure was to be employed as a means of ensuring that the residents as well as the facility ' s staff would better understand how to ensure and manage a resident ' s privacy. At 3:23pm during the state agency ' s monitoring visit on 11/28/2007, the QMRP presented a sign-in sheet that was dated 5/21/2007 for staff training on " appropriate clothing (for modesty), bathing, dressing, and grooming " . Of the twelve staff presently on the current work schedule, only two was in attendance and signed for the 5/21 training. There was no evidence on file at the time of survey to substantiate that the facility ensured that its staff received the proper and necessary training to maintain and manage resident privacy. 2. On 4/13/2007 the state agency conducted this facility ' s annual recertification and found the facility ' s practices to be deficient in the area of	I 222	I 222 1&2 Cross-reference response for W189 on federal report.	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	090159	A. BUILDING _____ B. WING _____	11/29/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARECO 02	6613 6TH STREET, NW WASHINGTON, DC 20012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 222	Continued From page 3 reporting injuries of unknown origin (W153). The provider submitted their plan of correction and indicated that " all staff have been retrained in implementing incident management procedures " on 5/10/2007. In addition, the facility further denoted that " the agency will strictly enforce its policy on holding individuals accountable, which may include termination for failure to report such occurrences. " At 3:37pm during the state agency ' s monitoring visit on 11/28/2007, the QMRP presented a sign-in sheet that was dated 9/11/2007 for staff training on " Incident Reporting " . Of the twelve staff presently on the current work schedule, only two was in attendance and signed for the 9/11 training. There was no evidence on file at the time of survey to substantiate that the facility ensured that its staff received the proper and necessary training to maintain and manage the reporting of injuries of unknown origin. 3. On 4/13/2007 the state agency conducted this facility ' s annual recertification and found the facility ' s practices to be deficient in the area of implementing a resident ' s behavior support plan (BSP) (W183 & W249). The provider submitted their plan of correction and indicated the following: a. For Citation #1 to address the behavioral supports for Resident #2, the facility ' s response indicated that " Staff [was] trained on implementation of the BSP's for all residents on March 9 2007. A second session was scheduled for those who missed the first offering. In addition, all staff [is] trained on behavior management prior to or upon deployment into the home ... All staff [has] been retrained on implementation of all BSP's including the one developed for Resident #2. Staff will not be	I 222		

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	09G169	A. BUILDING _____ B. WING _____	11/29/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARECO 02	6613 6TH STREET, NW WASHINGTON, DC 20012

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I 222	Continued From page 4 assigned to support residents until they have a fundamental understanding of the BSP. This acknowledgement will be documented. " At 3:40pm during the state agency ' s monitoring visit on 11/28/2007, the QMRP presented a sign-in sheet that was dated 5/22/2007 for staff training on " Behavior Support Plans ". Of the twelve staff presently on the current work schedule, only one was in attendance and signed for the 9/11 training. There was no evidence on file at the time of survey to substantiate that the facility ensured that its staff received the proper and necessary training to maintain and manage the implementation of a resident ' s behavior management plan. b. For Citation #2 to address the behavioral supports for Resident #3, the facility ' s response indicated that " Staff will receive additional training on implementing the active treatment routine for resident #3 to properly support her in managing behavior. " In addition, the facility further alleges that " the staffing patterns will be reviewed with the governing body to determine how best to support Resident #3 ' s [behavioral needs]. " At 3:40pm during the state agency ' s monitoring visit on 11/28/2007, the QMRP presented a sign-in sheet that was dated 5/22/2007 for staff training on " Behavior Support Plans ". Of the twelve staff presently on the current work schedule, only one was in attendance and signed for the 9/11 training. In addition, the QMRP was interviewed on 11/28/2007 at 3:45pm and she indicated " that the staffing pattern(s) were not changed to address this issue, but the team decided that more training was to be the best means of addressing this resident ' s needs. " There was no evidence on file at the time of survey to substantiate that the facility conducted the	I 222		

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	09G159	A. BUILDING _____ B. WING _____	11/29/2007

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I 222	Continued From page 5 meeting with the governing body or ensured that its staff received the proper and necessary training to maintain and manage the implementation of a resident ' s behavior management plan.	I 222		
I 226	3510.5(c) STAFF TRAINING This Statute is not met as evidenced by: The facility failed to ensure the provisions of this section as identified below: On 4/13/2007 the state agency conducted this facility ' s annual recertification and found the facility ' s practices to be deficient in the area of implementing infection control procedures to prevent the spread of communicable diseases (W455). The provider submitted their plan of correction and indicated that " staff will receive additional training on infectious controls by the Director of Nursing " . This action was to be effective and resolved by 5/31/2007. The facility ' s QMRP was interviewed on 11/29/2007 at 4:26pm and she stated that there have been several changes in the organizational structure of the agency and that she is not aware of who currently holds the title and position of Director of Nursing. In addition, she pointed out that the current organizational chart that was posted in the home was not current and does not show who currently holds the title and position of Director of Nursing. That survey team verified that the current organizational chart was dated 08/2007. There was no evidence presented or on file at the time of survey to substantiate that the Director of Nursing has conducted this training as stipulated on the Plan of Correction.	I 226	I 226 Cross-reference response for W189 on federal report.	

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I 260	Continued From page 6	I 260		
I 260	3512.1 RECORDKEEPING: GENERAL PROVISIONS Each Residence Director shall maintain current and accurate records and reports as required by this section. This Statute is not met as evidenced by: The facility failed to ensure the provisions of this section as identified below: Staff interview and record review on 11/28/2007 revealed the facility failed to ensure that staff received the proper support to ensure resident ' s privacy and implementation of their Behavior Management Plan(s) (BMP). [Reference Licensure Citation 3510.3]	I 260	I 260 Cross-reference response for W189 on federal report.	
I 500	3523.1 RESIDENT'S RIGHTS Each GHMRP residence director shall ensure that the rights of residents are observed and protected in accordance with D.C. Law 2-137, this chapter, and other applicable District and federal laws. This Statute is not met as evidenced by: The facility failed to ensure the provisions of this section as identified below: On 4/13/2007 the state agency conducted this facility ' s annual recertification and cited that " no system had been established to provide guardianship for consent or legally sanctioned advocacy " for Resident #3. The provider submitted their plan of correction and indicated that this deficiency would be resolved by 5/31/2007. The state agency conducted a	I 500	I 500 Cross-reference response for W124 on federal report.	

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I 500	Continued From page 7 monitoring visit on 11/28/2007 and found that Resident #3 was still without the services of any legally sanctioned advocate. The facility ' s Qualified Mental Retardation Professional (QMRP) was interviewed on 11/28/2007 at 3:17pm and she indicated that a request for guardianship had been submitted to the courts on behalf of this resident, but as of the date of the monitoring, no guardian had been assigned.	I 500		